August 13, 2009

TO: Division of Global Migration and Quarantine
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
Attn: Part 34 NPRM
Comments, 1600 Clifton Road, NE., MS
E–03, Atlanta, Georgia 30333

RE: (1) Proposed Removal of HIV Entry Ban
The H.R.3337 HIV Nondiscrimination in Travel and Immigration Act of 2007
Revision of 42 CFR Part 34 (Medical Examination of Aliens) Removal of Human Immunodeficiency Virus (HIV) from Definition of "Communicable Disease of Public Health Significance" – Notice of Proposed Rule Making (NPRM)
(2) Proposed Removal of references to ''HIV'' from the scope of examinations in its regulations

The Minnesota Department of Health's Division of Infectious Disease Epidemiology, Prevention and Control (IDEPC) appreciates the opportunity to comment on the proposed changes to the regulations regarding the removal of HIV from the definition of "Communicable Disease of Public Health Significance" and the changes to HIV testing from the scope of examinations.

The IDEPC fully endorses the H.R.3337 HIV nondiscrimination in Travel and Immigration Act of 2007 as the risks for HIV transmission are well-understood and lifting the travel ban will not increase the risk of transmission.

However, IDPEC does not endorse the removal of mandatory testing for all immigrant applicants. Instead, IDEPC endorses the second alternative approach listed in the Federal Register: "remove HIV infection from the list of communicable disease of public health significance, ...but continue mandatory HIV testing for all immigrant applicants..." We recommend that HIV testing remains a component of the overseas medical examinations for immigrants and refugees resettling in the United States but be designated as a Class B health condition. This will ensure a public health benefit on a number of levels listed below:

1. We strongly agree with the argument that "the medical examination offers a unique opportunity to both inform immigrants of the HIV status and link them with care." Refugees, in particular, are vulnerable to lack of information about their own health status and experience substantial disadvantage accessing and navigating the US health care system.
2. Many refugees come from regions of the world with significant HIV/TB co-infections. If a health care provider at the domestic health assessment knows

about this potentially serious co-infection, they will be able to ensure the refugee receives appropriate assessment and intervention. Co-infected persons experience a 7 to 10 percent annual risk of developing active tuberculosis compared to a 10 percent lifetime risk among immune competent persons. Early identification of these cases will greatly reduce the risk of active disease among these refugee arrivals.

3. Immunizations are a significant component of the domestic refugee exam and a requirement for the Adjustment of Status exam. If a health care provider knows a patient's HIV status, they will be able to utilize best clinical practice when administering live viral vaccines (i.e. MMR, varicella).
4. Although HIV is not a threat to the larger U.S. population, the disease is disproportionally greater in certain immigrant populations. This is due to many social co-factors, such as sexual networks, forced urban migration, health literacy, and religious beliefs. Minnesota 2008 data shows that foreign-born persons accounted for 19 percent of all new diagnoses and of those 39 percent were late testers (www.health.state.mn.us/hiv). In that same year, African-born persons accounted for 11 percent of new diagnoses and of those 41 percent were late-testers, which progressed to AIDS within one year of diagnosis. Late-testing for HIV is associated with denial and stigma, significant social factors that impact the individuals' health outcome. If state health departments and health care providers know a refugee's HIV status at the time of arrival, they will be able to link these individuals to care, prevention education, and resources soon after their arrival.
5. The federal government uses HIV/AIDS surveillance data to plan for prevention and care services both at national and local levels. These data determine the funds distributed to states under the Ryan White HIV/AIDS Treatment Modernization Act of 2006 utilized for providing drug assistance, health insurance, and other services to those living with HIV. Under the current system, surveillance staff is alerted to the arrival of immigrants or refugees who are HIV-positive. This notification serves two purposes. First, it ensures that individuals can be connected to care and other services available to those living with HIV. Second, it allows surveillance data to accurately depict the epidemic in Minnesota. The proposed change to discontinue testing overseas would eliminate this notification and given some of the issues raised above it is unlikely that these individuals would be tested early in their disease progression. Current Minnesota surveillance data shows that close to 40 percent of non-US born persons who test positive for HIV progress to AIDS within one year of HIV diagnosis compared to 29 percent of US-born individuals.

While we agree the public charge issue raised by CDC could be considered a reason for concern, initial research found little precedence to substantiate the argument put forth in the proposed rule. IDEPC views the benefits of good public health practice, as noted above, outweighing the current evidence (See attached document "Public Health Significance").

In conclusion, IDEPC urges CDC to continue HIV testing for immigrants and refugees departing for the United States and noting positive results as a Class B

condition, along with many other chronic conditions noted on the overseas exam. This would be consistent with good public health practices and be an important step toward ensuring care for HIV+ arrivals.

Sincerely,

Infectious Disease Epidemiology, Prevention and Control

Refugee Health Coordinator
Immunization, Tuberculosis, and International Health (ITIH) Section

STD and HIV Section

Attachment: Public Health Significance
HIV Comment submitted by the Infectious Disease, Epidemiology, Prevention and Control, Minnesota Department of Health

Proposed Rule: 42 CFR Part 34 (2 July 2009)
Removal of HIV Infection from Definition of Communicable Disease of Public Health Significance

1. It Is Unlikely that an Alien's HIV Positive Status Will Affect Their Status as a Public Charge

The Notice of Proposed Rule Making (NPRM) offers the argument that continued mandatory testing of an alien's HIV positive status may affect whether Department of Homeland Security (DHS) deems the alien as a public charge.

An alien can be ineligible under the Immigration and Nationality Act (INA) if there are circumstances that the alien is likely to become a public charge after admission despite any affidavit of support filed on the alien's behalf.[1] The government defines "public charge" as "an alien who has become (for deportation purposes) or is likely to become (for admission/adjustment purposes) 'primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense.'"[2] There are public benefits that are not elements of "public charge" determinations, including Food Stamps, Medicaid, Women, Infants, and Children (WIC), prenatal care, immunizations, nutrition programs, housing assistance and other non-cash benefits.[3] When determining admissibility or adjustment to permanent resident status, the Office of Refugee Resettlement (ORR) populations generally are not subject to "public charge" determinations.[4]

As noted in the NPRM, before an alien's immigration application will be approved, a sponsor must prove to DHS that they are able to provide support to the sponsored individual from an annual income at least 125 percent above the federal poverty level.[5] In addition, most immigrants are not able to receive means-based public benefits for five years after arrival to the United States and there are no data to indicate that HIV-infected immigrants seek public benefits at different rates than non HIV-infected immigrants after five years.[6] For these reasons, the federal Department of Health and Human Services Centers for Disease Control and Prevention (HHS/CDC) concluded that it is unlikely that an alien will qualify for most public benefits based on income eligibility requirements.[7]

Although individuals with HIV-positive status would likely not fall under the category of "institutionalization for long-term care,"—which would include aliens in a nursing home or mental

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[1] Immigration & Nationality Act § 212(a)(4).
[2] 64 F.R. 28689.
[3] State Letter #05-02 from Nguyen Van Hanh, Director, Office of Refugee Resettlement , to State Refugee Coordinators, National Voluntary Agencies, Other Interested Parties, *available at* http://www.acf.hhs.gov/programs/orr/policy/sl05-02.htm.
[4] *Id.*
[5] 74 F.R. 31798, 31805.
[6] *Id.*
[7] *Id.*

health institution[8]—health is a consideration in determining public charge status. The United States Citizenship and Immigration Services (USCIS), formerly known as the INS, and Department of State (DOS) offer a test that considers the "totality of the circumstances," including health as a mandatory factor. [9] However, in a 1999 Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, the USCIS (then INS) clarified that health services for testing and treatment of symptoms of communicable diseases are not considerations for public charge purposes.[10]

Based on calculations of access to public benefit, factors in determining whether an individual is a public charge, and immigration requirements, it is unlikely that one's HIV status will affect whether an alien receives the status of a public charge.

2. Removing Mandatory Testing for HIV Would Place a Substantial Burden on State Public Health Departments and Agencies

The proposal to remove mandatory HIV testing will likely transfer responsibilities and costs of HIV/AIDS in immigrants to state agencies, notably state public health departments.

In fact, the HHS/CDC acknowledged the economic significance of the Proposed Rule. The proposed rule would likely create a burden of excessive costs to state public health departments due to additional preventive work necessary to mitigate co-infection risks, greater duties and needed resources to conform with best clinical and public health practices, and initial HIV testing at the state level for strong prevention and care services. While the proposed rule considers the economics of treatment costs, it does not consider the costs and resources required for state public health departments to provide education, encourage testing, and provide treatment and services to those that may learn of their positive HIV status after their arrival to the United States—the NPRM recognizes this omission by noting that its analysis did not include non-healthcare costs.[11]

In order to accurately assess the economic impact of the Proposed Rule, HHS/CDC should examine the added costs and responsibilities of HIV preventive work and care for state health departments if there is no mandatory HIV testing pre-arrival to the United States.

3. The Removal of Mandatory HIV Testing Conflicts with the Remaining Mandatory Tests

The proposed removal of mandatory HIV testing conflicts with current understandings of health conditions that remain elements of mandatory testing, such as infectious syphilis and gonorrhea.

CDC/HHS propose that HIV should not remain on the list of "communicable diseases of public health significance" or be required for mandatory testing due to the fact that HIV is not introduced, transmitted, or spread through casual contact.[12] Since the spread of HIV typically occurs through unprotected sex, needle or syringe-sharing, and mother-to-child transmission through birth or breast-feeding, the U.S. population is not at significant risk through general contact.[13]

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[8] 64 F.R. 28689.
[9] *Id.*
[10] *Id.* at 28693.
[11] *Id.* at 31805.
[12] *Id.* at 31798.
[13] *Id.* at 31800.

This reasoning is compelling, but remains at odds with other conditions that remain on the list of "communicable diseases of public health significance" and still require mandatory testing. For example, infectious syphilis and gonorrhea will remain on the list, even though they have parallel modes of transmission as compared to HIV. There was an express provision in the INA for HIV to remain on the list of "communicable diseases of public health significance" until the Tom Lantos and Henry Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 amended the INA.[14] No similar express requirement exists for the other conditions that remain on the list.

If the Proposed Rule is implemented, the current list of "communicable diseases of public health significance" and, thus, those conditions that require mandatory testing, will not necessarily reflect current medical or public health understandings.

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[14] *Id.* at 31798.